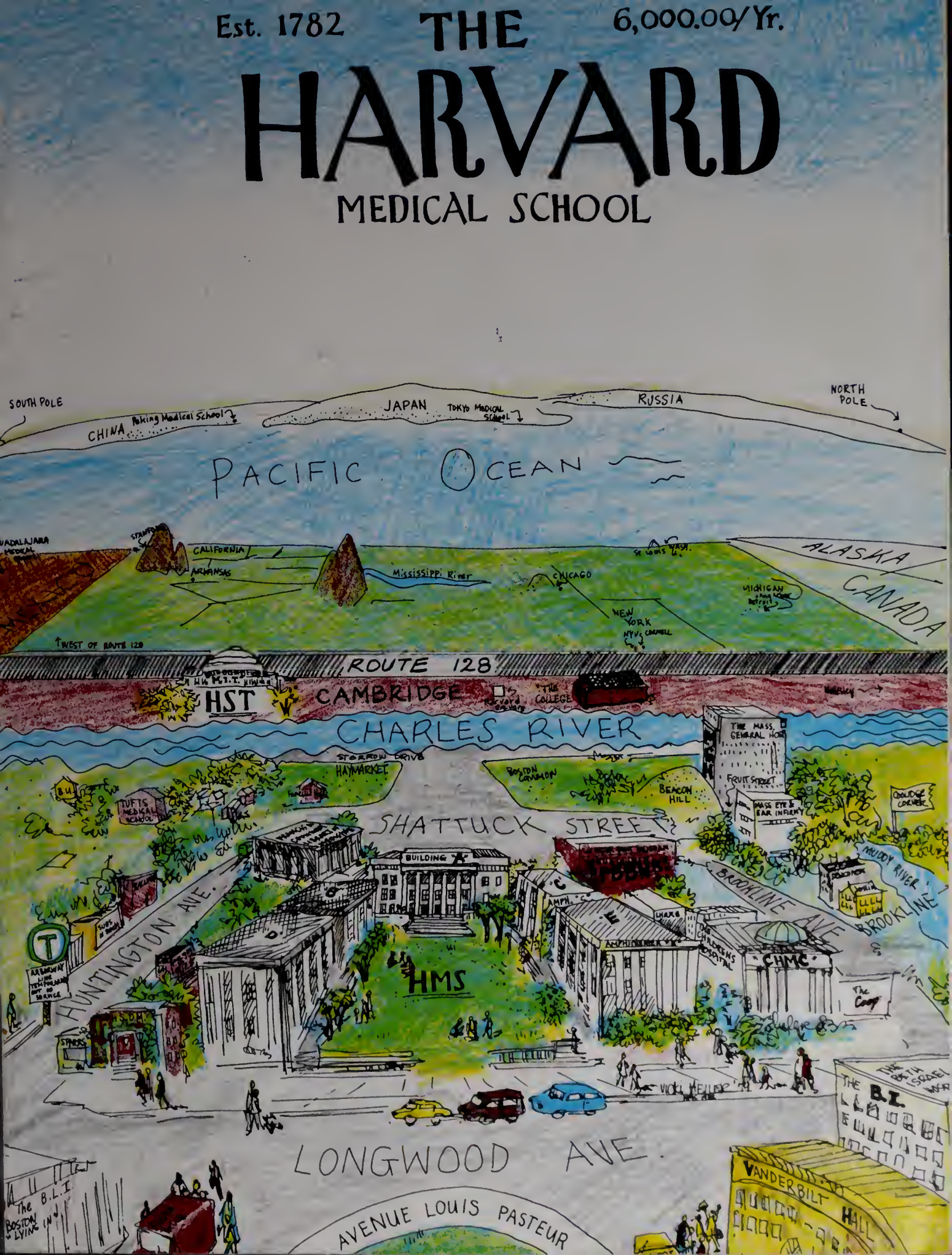
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Harvard Medical Alumni Bulletin

January/February 1979
volume 53 number 3

Cover: Harvard Medical School and beyond, as seen through the eyes of first year student Vicki Heller. Ms. Heller is the winner of the First Annual Harvard Medical School T-Shirt Design Contest, which was originated by classmate David Goldman. Second and third place winners are Bonnie Pinto-Swift of the Student Financial Aid Office and Clara Jones '81.

Credits: Cover, Vicki Heller; pp. 6, 8, 12, 15, 17, 19, Christopher Morrow; pp. 10-11, Ken Maryanski; p. 22, reprinted from *Acta Eruditorum* (Leipzig, 1686); p. 24, reprinted from John Hutchinson, "On the Capacity of the Lungs" (1846); p. 35, courtesy of Mrs. Phyllis Coons. We also wish to thank Maurice deG. Ford, Esquire and Thomas G. Gutheil, M.D. for posing as themselves.

Both Ms. Heller's and Ms. Pinto-Swift's designs are for sale in a rainbow of colors: mint green, yellow, tan, light blue, white and, of course, crimson. They are available in small (34-36), medium (38-40), large (42-44), and extra large (46-48); children's sizes are also available. The price is $3.50 in cotton or $3.65 in a blend of 50% cotton, 50% polyester. (Add 10¢ for crimson.) Include $1.00 for postage costs. For mail orders, make checks payable to the Student Affairs Office. When ordering, specify either "The Harvard Medical School" or "Vanitas" and include the address to which the T-shirt is to be sent. Delivery takes three to four weeks. All inquiries and orders can be directed to: Ms. Bonnie Pinto-Swift, Student Affairs Office, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts 02115 (617) 732-1575.

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Overview

Espirit de HMS

The Alumni Association has planned three social events in 1979 to give itinerant and far flung alumni/ae the opportunity to rendezvous and dine together. As a further enticement, these occasions have been planned to coincide with three upcoming professional meetings.

The first gathering is a dinner at the Bohemian Club in San Francisco on Monday, March 26, 1979 for alumni/ae in town to attend the American College of Physicians annual meeting, as well as alumni/ae and spouses who live in the San Francisco Bay area. On Monday, October 22, 1979 a dinner will be held at the Art Institute of Chicago for alumni/ae and spouses who live in the Chicago area and for those who are attending the American College of Surgeons' Clinical Congress. The final affair planned is a reception on Sunday, November 4, 1979 at the Washington Hilton. It is a chance for alumni/ae and spouses from the Washington and Baltimore area to meet with those in town to attend the meeting of the Association of American Medical Colleges.

Prior to each event, letters with full details will be mailed to graduates in San Francisco and Chicago who might be interested in attending. The Alumni Association does not have a list of potential attendees for the meeting of the Association of American Medical Colleges. Anyone interested who does not receive a letter, please write to the Alumni Office, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts 02115 for further information.

Richard Ryan steps up to associate dean

Dean Tosteson's administration has been augmented recently, but with an individual already serving in an administrative capacity at Harvard Medical School: Richard Ryan, Ph.D. is settling into the newly-created position of Associate Dean for Medical Services. The change is one of title and reflects the greater responsibilities that have come under Dr. Ryan's aegis as Assistant Dean for Government Medical Services.

The years that Dr. Ryan previously spent at HMS — from 1971 to 1974 as Assistant Dean for Clinical Programs and from 1974 to 1975 as special assistant to Dean Ebert — have given him a solid grounding in the complexities of medical school administration. In the years since, Dr. Ryan served as director of the West Roxbury VA Hospital and of Medical District One for New England's VA hospitals. He is currently a consultant to the VA department of health services research and development in Washington, D.C.

From his long-standing association with the Veterans' Association, Dr. Ryan has the depth of understanding required for an ongoing aspect of this new position. He will maintain his role of liaison with the four VA hospitals affiliated with Harvard, with the VA central office, and with other federal health care providers. Activities related to the Medical School at the School of Public Health, the state department of public health, and other government and community organizations will also come under his purview.

Remaining within the administrative unit directed by Dr. Mitchell W. Spellman, Dean for Medical Services, Dr. Ryan will be responsible for the collection, analysis, and reporting of relevant data. He will also assist in coordinating graduate medical education and research programs in the Harvard hospitals.

Until his new appointment, Dr. Ryan had been working concurrently as director of planning for the Affiliated Hospitals Center.

Clement Sledge named to Brown Professorship

Dr. Clement B. Sledge, chief of orthopedic surgery at the Robert B. Brigham and Peter Bent Brigham hospitals, was recently named the John B. and Buckminster Brown Professor of Orthopedic Surgery at Harvard Medical School. Dr. Sledge has been professor of orthopedic surgery at Harvard and has directed the services at both Brigham hospitals since 1970.

He is the fifth individual to be named to the professorship, which was established in 1915 by a bequest of Buckminster Brown (1819-1891). His father, John B. (1784-1862), founded the orthopedic infirmary at the Massachusetts General Hospital and the younger Dr. Brown devoted himself to the treatment of deformities, particularly malformations of the feet.

At the Peter Bent Brigham Hospital, the orthopedics department is a general one caring for trauma patients, and doing orthopedic and special reconstructive surgery. According to Dr. Sledge, hip, knee, and other joint replacements are the applied side of orthopedics. "Orthopedics has entered the cellular stage," he noted. "Cartilage, the connective tissue lining the joints, is difficult to study, in part because of widely separated cells. But now it can be grown, and study in laboratories and in animals is helping us to understand its nature. Unlike skin, cartilage does not replace or renew itself, and it has little ability to heal."

At the Robert B. Brigham, the emphasis is on reconstructive and joint replacement surgery. Dr. Sledge's research is focused on the elucidation of the way rheumatoid arthritis destroys a joint, and how this can be reversed or prevented.

Dr. Sledge and Dr. Henry Mankin, chief of orthopedic surgery at the Massachusetts General Hospital, are responsible for residency training programs in orthopedic surgery at the MGH, the two Brighams, the Beth Israel, and Children's Hospital Medical Center; currently forty-two physicians are in the training program, which requires two years of surgery followed by three years of orthopedic surgery.

Cerebral palsy on the receiving end

Funding for medical research, linked inextricably as it is to the economy, has waned in the past several years. There has not been a concurrent drop, however, in the need for the research dependent upon such funds, making donations that support research — like the one recently given to Harvard by the William Randolph Hearst Foundation — doubly appreciated.

The gift of $500,000 to support research in the area of pre- and perinatal research was announced at the December 14 Annual Dinner of United Cerebral Palsy. Income from the fund will be presented annually to a member of the HMS faculty whose work emphasizes factors important to the prevention of neuromotor disabilities.

The gift honors Ethel and Jack Hausman, and Isabel and Leonard H. Goldenson, two couples who were among the founders of the United Cerebral Palsy Organization in 1950. Since then, their leadership and support of programs on behalf of handicapped children and adults has continued uninterrupted.

Cerebral Palsy is one of several neuromotor disorders whose causes, it is hoped, will be better identified and understood through further research. Neuromotor disabilities block or scramble the signals between the brain and the body's muscles, and prevent voluntary movements from being carried out in normal fashion. Dr. William Berenberg, professor of pediatrics and chief of the cerebral palsy unit at the Children's Hospital Medical Center, defines cerebral palsy as muscular disability caused by brain damage. Other neuromotor disabilities that are genetic, environmental, metabolic or infectious in origin will also benefit from the research.

Dr. Berenberg, who is chairman of the United Cerebral Palsy Research Advisory Committee, and national vice-president for medical affairs for UCP, spoke at the dinner, and told of progress made in recent years toward preventing or alleviating CP.

One paradox of the disorder, Dr. Berenberg explained, is that although many of its causes have been eliminated or greatly reduced, its incidence of about 1 per 1000 births has remained steady. Progress in medical research and technology, which wiped out some causes, has at the same time contributed to the "increase."

Dr. Berenberg espouses a philosophy of treatment that emphasizes the need to deal with not only the physical manifestations of CP but the emotional problems of the handicapped child and the family too. "We must not raise expectations but we can also be very encouraging and supportive. The gift from the Hearst Foundation will help us to recruit the finest scientific talents to aid in solving some of the most troubling medical problems still before us."

Erratum

In the July/August *Alumni Bulletin*, the biographical note about Donald N. Medearis Jr. '53 that followed his article "Dollars, dogs and diapers, or do we really pamper our children?" said that he returned to Harvard after being dean of the University of Pittsburgh School of Medicine. This unfortunately omitted the three years during which he was director of the department of pediatrics at Cleveland Metropolitan General Hospital and professor of pediatrics at Case Western Reserve University School of Medicine.

Bulletin Board

Want to place an ad?

1) The *Alumni Bulletin* is published six times a year. The dates of publication and copy deadlines are: **Jan./Feb. — Jan. 1; Mar./Apr. — March 1; May/June — May 1; July/Aug. — July 1; Sept./Oct. — Sept. 1; Nov./Dec. — Nov. 1.** 2) Per word (single insertion) 10 word minimum, 50¢; Per word 2 times in one contract year, 45¢; Per word 6 times in one contract year, 40¢; 3) Payment for all insertions must be received with the copy. 4) Post Office box number counts as two words. Telephone numbers count as one word. No charge for Zip Code. We are unable to accept HMAB box numbers. 5) Send orders to: Harvard Medical Alumni Bulletin, 25 Shattuck St., Boston, MA 02115

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The management of health

The Executive Programs in Health Policy and Management will hold three courses on aspects of health care management this spring at the Harvard School of Public Health. The programs are designed to provide training in management and analytic skills for senior managers, policymakers, planners and regulators in health care delivery and health-related organizations.

The first program, Managing Multi-Institutional Collaboration, will be held April 22-28, 1979 and will focus on managerial and behavioral skills. Applications are due by March 1, 1979. The Program in Health Policy, Planning and Regulation will be conducted June 3-22, 1979 and will concentrate on analytic and managerial skills. Applications are due April 16, 1979. The Program for Health Systems Management will be conducted June 24-August 3, 1979 and is designed to develop skills of leadership, resource allocations and institutional policy and strategy. Applications for this program are due by March 15, 1979.

Additional information and applications should be requested from: Associate Director, Executive Programs in Health Policy and Management — Dept. NR, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115.

Crossroads to Africa

Crossroads Africa, Inc., a non-profit organization that has sent more than 5,000 volunteers to Africa in the last twenty-one years to live and work with rural villagers, is now accepting student and faculty applications for its Summer 1979 (July and August) Medical/Health Projects in Africa. Fred Feinsod '75 of the department of tropical public health at the Harvard School of Public Health is a special medical consultant to the program.

The Ministeries of Health in Sudan, Nigeria, and The Gambia have invited Crossroads teams — with ten Americans per team — to join African medical students and specialists for the eight summer weeks in projects aimed at providing clinical medical services and improving primary health care. The teams will examine the existing health care delivery systems and will actively participate in improving primary health care: combating malaria, advising on better nutrition, immunizing rural village populations, and helping to bolster traditional health delivery systems.

There is a need for both leader and student applicants. All expenses and a $200 honorarium are paid to leaders; for students, the Crossroads organization helps as much as possible to raise the necessary funds. For more information or an application, contact Crossroads Africa, Inc., 150 Fifth Avenue, New York, New York 10011, (212) 242-8550.

PROMOTIONS

Professor

Gerald D. Fischbach: pharmacology

Associate Professor with Tenure

Samuel A. Latt '64: pediatrics

Senior Associate

Madhukar Anant Pathak: dermatology (biochemistry)

Senior Research Associate

George Hauser: biological chemistry

Associate Professor

Blanche P. Alter: pediatrics
Anthony R. Bellve: physiology
Richard M. Bergland: surgery
Victoria Chan-Palay '75: neurobiology
Robert B. Colvin '68: pathology at the Massachusetts General Hospital
Geoffrey M. Cooper: pathology
Melvin L. Depamphilis: biological chemistry
Marc A. Dichter: neurology
R. Bruce Donoff '67: oral surgery at the MGH
Leonard L. Ellman '68: medicine at the MGH
Richard W. Erbe: pediatrics
Kenneth H. Falchuk '66: medicine
Lawrence A. Falk, Jr.: microbiology and molecular genetics at the New England Regional Primate Research Center
Herman K. Gold: medicine at the MGH
Lloyd A. Greene: neuropathology
Robert I. Handin: medicine at the Peter Bent Brigham Hospital
Peter V. Hauschka: oral biology and pathophysiology
E. Tessa Hedley-Whyte: pathology at the New England Deaconess Hospital
James A. Herd: psychobiology in the department of psychiatry at the NERPRC
Steven W. Matthysse: psychobiology in the department of psychiatry
Robert W. McCarley '64: psychiatry at the Massachusetts Mental Health Center
Robertson Parkman: pediatrics at the Children's Hospital Medical Center
Paul H. Patterson: neurobiology
Geraldine S. Pinkus: pathology at the PBBH
Barbara H. Sanford: pathology at the Sidney Farber Cancer Institute
Joseph R. Shaeffer: medicine (biochemistry)
William U. Shipley '66: radiation therapy at the MGH

Michael L. Steer: surgery
Ann E. Stuart: neurobiology

Associate Clinical Professor

John D. Constable '52: surgery
Angelo J. Eraklis '58: surgery
H. Mackenzie Freeman: ophthalmology
Sheldon D. Kaufman: medicine
Kenneth J. Welch '43B: surgery

Assistant Professor

Heidelise Als: pediatrics (psychology)
Ellen L. Bassuk: psychiatry at the Beth Israel Hospital
Dale J. Benos: physiology
James L. Carpenter: comparative pathology
Sanjay Datta: anesthesia
Alvin E. Davis III: pediatrics
James F. Dice, Jr.: physiology
Ursula C. Drager: neurobiology
Argiris Efstratiadis: biological chemistry
Ellen Eisenberg: oral medicine and oral pathology
John T. Fallon: pathology at the MGH
Eric Frank: neurobiology
H. Harris Funkenstein '67: neurology at the PBBH
Lee Goldman: medicine at the PBBH
Mark I. Green: pathology
Dirk K. Greineder: medicine
Thomas G. Gutheil '67: psychiatry at the MMHC
Andrew C. Jackson: pediatrics (physiology)
Robert A. Johnson: medicine at the MGH
Aubrey J. Katz: pediatrics
Kenneth R. Kenyon: ophthalmology at the Massachusetts Eye and Ear Infirmary
Ban-an Khaw: pathology
Shukri F. Khuri: surgery
Daniel K. Kido: radiology at the PBBH
Lewis A. Kirshner: psychiatry at the Mt. Auburn Hospital
J. Philip Kistler: neurology at the MGH
Henry Klapholz: obstetrics and gynecology at the BI
John K. Koster, Jr.: surgery
Arthur L. Lage: veterinary medicine in the department of pathology at the Animal Resources Center
Story Landis: neurobiology
Michael N. Margolies: surgery at the MGH
Thomas J. Moore: medicine at the PBBH
Jeffrey H. Newhouse '67: radiology at the MGH
Stuart H. Orkin '72: pediatrics
Robert T. Osteen: surgery
Dennis J. Selkoe: neurology
Juan R. Serur: radiology
Glenn D. Steele Jr.: surgery
Arthur J. Sytkowski: pediatrics at the MGH
Roger S. Williams: neurology
Ken R. Winston: surgery at the PBBH and at the CHMC

Assistant Clinical Professor

Lloyd M. Aiello: ophthalmology
Solomon Berg: surgery
B. Hugh Burdette: oral diagnosis and oral radiology
Terry P. Hadley: dermatology
Tatsuo Hirose: ophthalmology
David Van Buskirk '57: psychiatry

Principal Associate

George C. Sornberger: medicine (biostatistics)

Principal Research Associate

James E. Byram III: pathology
James M. Krueger: physiology
Nancy S.F. Ma: pathology (cytogenetics)
Marco T. Nunez: medicine (biochemistry)
Seizaburo Sakamoto: oral biology and pathophysiology

Lecturer

Vernon N. Reinhold: biological chemistry

APPOINTMENTS:

Professor

Philip B. Holzman: psychiatry
Joseph B. Martin: neurology
Augustus A. White III: orthopedic surgery

Clinical Professor

Robert J. Haggerty: pediatrics

Associate Professor

Edward D. Bird: neuropathology at the McLean Hospital

Assistant Professor

Diana H. Ausprunk: anatomy in the department of surgery
Leila Beckwith: pediatrics (psychology)
Thomas M. Badger: obstetrics and gynecology (biochemistry)
Paul H. Chapman '64: surgery at the MGH
James W. Fett: pathology
Jeffrey S. Flier: medicine
John J. Godleski: pathology at the PBBH
Benjamin Liptzin: psychiatry
Robert J. Nicolosi: comparative pathology
James G. Rheinwald: physiology
Joseph F. Simeone: radiology at the MGH
Cornelis P. Terhorst: pathology
Johan Zwann: ophthalmology

Assistant Clinical Professor

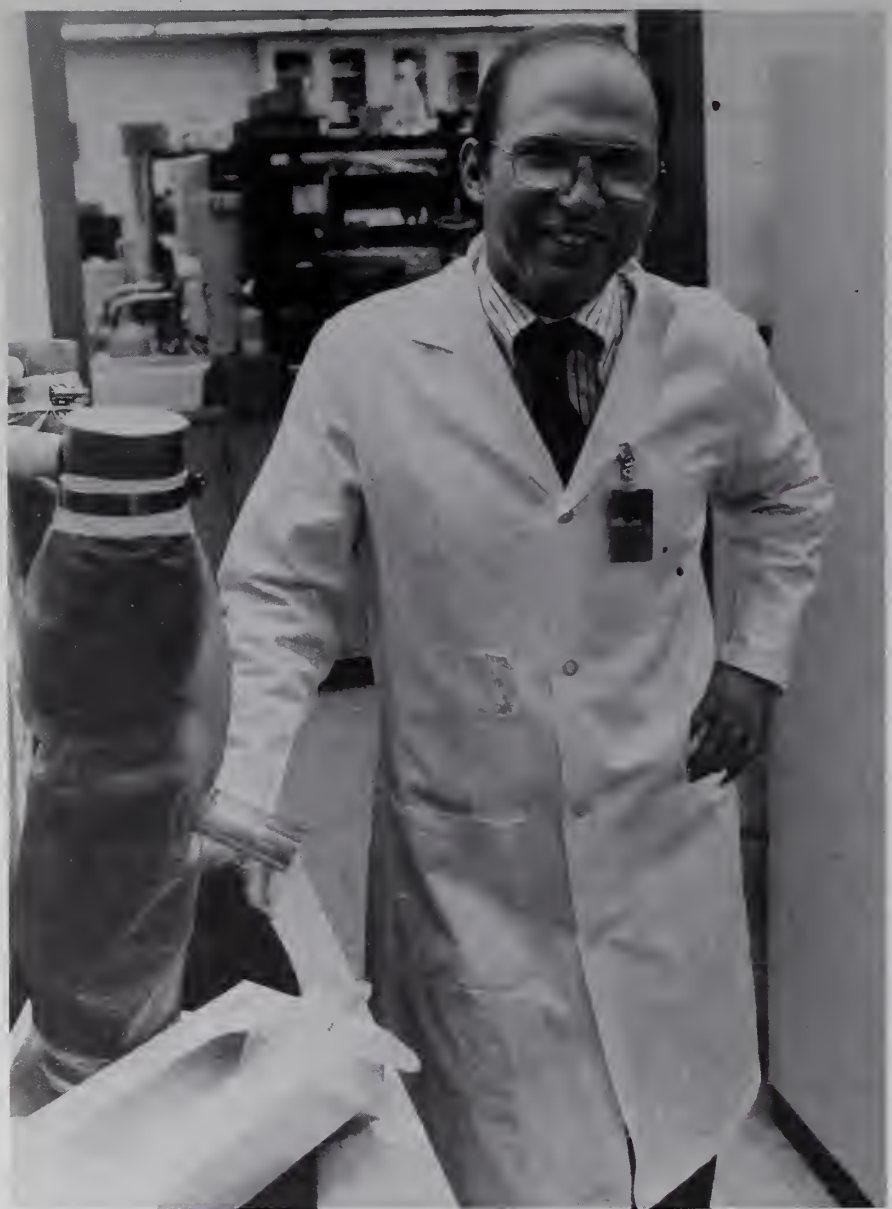
Park E. Dietz: psychiatry at the MH
Ferris J. Siber: radiology

Lecturer

Paul H. Curtiss, Jr.: orthopedic surgery

Through the Looking Glass

The proliferation of academic endeavors
under the aegis of the Medical School
often leaves alumni/ae feeling rather out of touch.
As a remedy, the *Bulletin* inaugurates a series
of periodic check-ups of HMS's ever-expanding horizons.



Peter Goldman: organizing a clinical pharmacology program for HMS.

Pharmacology, Research, and the Clinical Connection

by Deborah W. Miller

The path back to health is lined with medications — good, bad and even indifferent. Where potions of magical herbs were once the domain of the healer, a plethora of synthetic and natural drugs now confront physicians and makes the PDR more unwieldy — and the information in it more essential — each year. The study of pharmacology, understanding the properties and functions of drugs, is not new to Harvard Medical School, but only recently has a program been implemented for a more systematic study of the therapeutics and the clinical toxicity of pharmacological substances. Peter Goldman, M.D., was recruited from the National Institutes of Health in 1972 to come to HMS and develop a program in clinical pharmacology that would establish itself in the Quadrangle as well as in area hospitals. "All branches of medicine study and use drugs, but clinical pharmacology itself is an underpopulated area. The need for clinical pharmacology, like that for a national energy policy, has been slow in being born. Where this discipline fits into the organization of medicine has not been clear because it combines clinical applications with strong basic science components."

Over the last six years, Goldman — who is the Maxwell Finland Professor of Clinical Pharmacology and commutes between the new Seeley Mudd Building and the Beth Israel — has built up a solid clinical pharmacology unit, with five faculty and seven fellows, that has broken new ground, particularly in regard to pediatric pharmacology.

The one year old Poison Control Center for the state of Massachusetts that is based at Children's Hospital Medical Center testifies to the prowess of Goldman and his associates. The increasing concern for the toxicology of various medicines and other substances in the environment made members of the clinical pharmacology unit realize that a comprehensive poison center would be an ideal site for an amalgamation of service, teaching and research. Massachusetts initially had set up several small poison control "hotlines" scattered throughout the state, one of which was housed at Children's. The state recently centralized the Poison Control System and designated Children's as its headquarters, giving the MPCC the distinction of being the only poison center in the country with the direct participation of an academic clinical pharmacology unit. The MPCC, believes Goldman, can be a prototype for centers in other states in providing comprehensive and accurate information to both the medical profession and the general public.

Directed by Frederick Lovejoy, MD., assistant professor of pediatrics and a clinical pharmacologist-toxicologist, the center is staffed by twelve poison information specialists — pharmacists and nurses. Their expertise provides diagnostic and therapeutic aid to callers ranging from the parent whose child has downed the floor cleaner, to the physician from a small town in Massachusetts who needs current data on the treatment for a particular drug overdose. The emphasis of the center on the problem of clinical toxicology — specifically, overdosing — is due to the influence of the HMS group; before their involvement, the MPCC had no resident toxicologist.

In 1977, the MPCC responded to 33,000 calls, ninety-five per cent of which were for actual exposure; signs or symptoms were present in eighteen per cent and three per cent required hospitalization. Over three-quarters of the calls came from the public, and the majority related to children under five years who had ingested a toxic substance; six per cent of these however, were exposed by inhalation and seven per cent by skin or mucous membrane. The offending agents included medicinal drugs, household products, biologic poisons, industrial poisons, and drugs of abuse.

Educationally, the Poison Control Center is a good example of medical practice in the best of all possible worlds. "It is probably one of the few areas where specialists from many disciplines are part of a unified approach to a clinical problem," says Goldman. Discussions involve physicians, surgeons, pharmacists, nurses, toxicologists, and pharmacologists. Medical students are introduced to clinical toxicology during either their clerkship in pediatrics or one of several electives in clinical pharmacology and toxicology. Both students and clinical pharmacology fellows become familiar with the center's information resources and learn how to respond to cases of presumed poisoning.

"Questions come up repeatedly about the meaning of the 'approved indications' or the patient's right to choose his or her own therapy. Few physicians," asserts Goldman, "seem to be knowledgeable about the implication of the emerging role of pharmacy in providing drug information services and unit dose, as well as in attempting to improve medication compliance. It is important that physicians know how to integrate their regular activities with these new services and even how to help evaluate their utility."

Germ-free isolator

Package inserts often state that a drug is not approved for use in children under a certain age, because generally there is insufficient information for approval, rather than because these drugs are inherently dangerous. Indeed, reveals Goldman, many times these drugs must be used by pediatricians simply because there are no others available. The clinical pharmacology division is interested in systematically recording the results of using these drugs, to obtain reliable data. "Therapeutics in pediatrics is largely inferential, taking advantage of systematic studies carried out in adults and then extrapolating to children. Children are orphans of research, in part because of ethical problems of using them as research subjects, and in part because few pediatric centers have the volume of patients seen by adult practitioners."

Physicians need accurate information about the likelihood of both adverse and beneficial results from what they prescribe for their young patients. Data on drug use in the pediatric population is now collected in a program modeled after the Boston Collaborative Drug Surveillance Program, established by Herschel Jick '56 over ten years ago. A former fellow of the clinical pharmacology group — Allen Mitchell, M.D., now assistant professor of pediatrics and assistant in clinical pharmacology and medicine at Children's — oversees this study of hospitalized children.

Patient characteristics including age, sex, and genetic background are correlated with the drugs being taken and with either any adverse reactions or "events" which happen. This

> **"Few physicians seem to be knowledgeable about the implication of the emerging role of pharmacy."**

format enables researchers to quantify the results of drug therapy and ultimately, they hope, to identify previously unrecognized adverse drug reactions. Some of the events that a patient experiences, such as seizures, may in fact be unperceived drug reactions. An interesting application of this approach appears in the newborn nursery, according to Goldman. "If we have inadequate recorded experience with preadolescents, we have even less with neonates, who only recently have begun receiving intensive drug therapy. We don't know if they will have similar adverse reactions because their bodies are so undeveloped. Our monitoring indicates that untoward events such as gastrointestinal bleeding are rather high in the newborn experience, and suggests that many such events may be unperceived adverse drug reactions. We hope eventually to determine whether or not empirical associations exist between such events and prior drug therapy."

In addition to large enterprises such as the MPCC and the Drug Surveillance Program, a variety of smaller activities of the clinical pharmacology division enter into the life of the hospitals and Harvard's clinical departments. A consulting pharmacology service is provided for patients having problems of drug therapy. Individual faculty consult on the pharmacy and therapeutics committees and the human experimentation committees of the division's constitutent hospitals — the Peter Bent Brigham, the Beth Israel and Children's. When he was at the Peter Bent Brigham, Reynold Spector, M.D., formerly associate professor in medicine, and now head of the clinical pharmacology unit at the University of Iowa, monitored the hospital drug use — particularly antibiotics such as gentamicin and amikacin — in determining whether an educational or regulatory approach was indicated for their optimal use. Assistant professor of medicine, Paul Friedman's ('69) interest in establishing the mechanism of action of anticoagulant drugs has led to studying the role of Vitamin K in normal coagulation and how warfarin may act to inhibit its effect. He has also developed some new drug assays for the Longwood area hospitals.

As might be expected, the group's members are in demand by the FDA, the Center for Disease Control and other outside agencies, to consult on clinical trials of experimental and approved drugs. Joseph Ingelfinger, M.D., assistant professor in clinical pharmacology, has a variety of clinical problems under investigation: the efficacy of steroids in the treatment of acute asthma, the occurrence of mood changes during various antihypertensive treatment regimens, and the effect of dietary fiber on drug absorption. He is also working on innovative methods — including using the telephone — to monitor the progress of patients with psoriasis who have received the new psoralen treatments.

The clinical pharmacology group continues to offer consultation in the development of protocols relating to the study of drugs. Unfortunately most consultation has been sought only to interpret results already obtained. An interhospital forum for the design of drug related studies would not only have a pedagogic value, emphasizes Goldman, but might aid in the design and funding of studies sponsored both by federal grants and the pharmaceutical industry.

Studies of another factor that can strongly affect patient outcome — the accuracy of the drug assay used to predict the course of further drug therapy — have been undertaken by Goldman and Ingelfinger. Concerned that inaccurate serum concentrations of digoxin, anticonvulsants, like phenobarbital and phenytoin, and various antibiotics might be the basis for erroneous decisions about dosage adjustment for these drugs, they set out to evaluate laboratory performance. Both conventional quality control samples and intentionally simulated clinical specimens were submitted to four Harvard hospital laboratories and two commercial vendors. The results showed a greater variability for simulated clinical specimens, and the researchers also found that the performance of some of the labs was not that good. As Goldman explains, "Investigating the accuracy of lab tests becomes not only a matter of good patient care, but a policy issue with implications for cost reimbursement and government regulations for drugs permitted on the market. Lots of attention is given to those values — for example in establishing whether a drug is toxic or a potential suicide hazard."

Goldman himself seems able to pursue his research interests despite his administrative tasks. "These six years have been educational for me," he marvels. "I've become familiar with issues I never thought about, let alone investigated." Studying the role of the intestinal bacteria in the metabolism of toxic and therapeutic agents, currently he is focusing on the metabolic reactions of nitroimidazole drugs such as metronidazole (Flagyl) that may explain their efficacy and toxicity. He also teaches in three postgraduate courses — in pediatrics at Children's, in the department of medicine at the Peter Bent Brigham, and in obstetrics at the Boston Hospital for Women — "Data is accumulating rapidly on the possible teratological consequences of drugs taken during pregnancy, but making such decisions is still a murky business.

"Our research cuts across categorical lines — gynecology, gastroenterology, neurology," and, he says, it is part of the division's educational goal to look for common principles among its investigations into drug related practices in different clinical areas. Goldman hopes to establish the same kinds of "bridges" with other clinical specialties that Lovejoy and Mitchell have constructed with pediatrics and that Ingelfinger and Spector have constructed with medicine — making clinical pharmacology an integrated part of the HMS experience.

On "scrubbing in

A lawyer looks at psychiatry and a

by Maurice deG. Ford

Lawyers are often a thorn in the side of mental health professionals, especially at the present time, when the mantle is being passed from the civil rights advocate, to the women's rights advocate, to the patient rights advocate. I became intrigued with the seemingly unholy union of the law and psychiatry while working one summer at the Community Legal Assistance Office, one of the early neighborhood law offices established next to two housing projects in Cambridge. I was overwhelmed by all that we mere lawyers did not know about the problems of the urban family and our failure to make true changes in the lives of our clients, whose poverty was cancerous. As lawyers, we found ourselves in the middle, trying to be advocates on both legal and sociological fronts. When we analyzed what stance student lawyers were taking at the neighborhood law office and at other "helping" organizations such as the Harvard Legal Aid Bureau, Voluntary Defenders, and Prison Legal Assistance Project, we discovered much confusion about the lawyer's proper role.

In an attempt to clear up the confusion, we tried an experiment, calling in social workers and psychiatrists to help us identify the issues that lawyers could be most helpful with and those that were best addressed by other agencies. What resulted was the Harvard Family Law Project — which is still going strong — and which assisted lawyers in interviewing techniques, and evaluating data from, and learning the language of, psychiatry and the social sciences. Several years later, I became the observer. Some of the young psychiatrists working in our neighborhood law office brought me to another sort of den — the Massachusetts Mental Health Center — to see firsthand what the universe in which they trained was like.

I have now spent some time "scrubbing in," roaming the wards, experiencing the ambience of "milieu therapy," and getting a sense of what psychiatrists read, think and feel with their patients. There has been a method in this madness. My method has been to ferret out the reasons for the many conflicts lawyers and psychiatrists invariably seem to experience. These helping professions, rather than complement each other, are all too often mutually suspicious. The new breed of mental health lawyer comes on, in the opinion of many psychiatrists, far too strong, brusque and insensitive to

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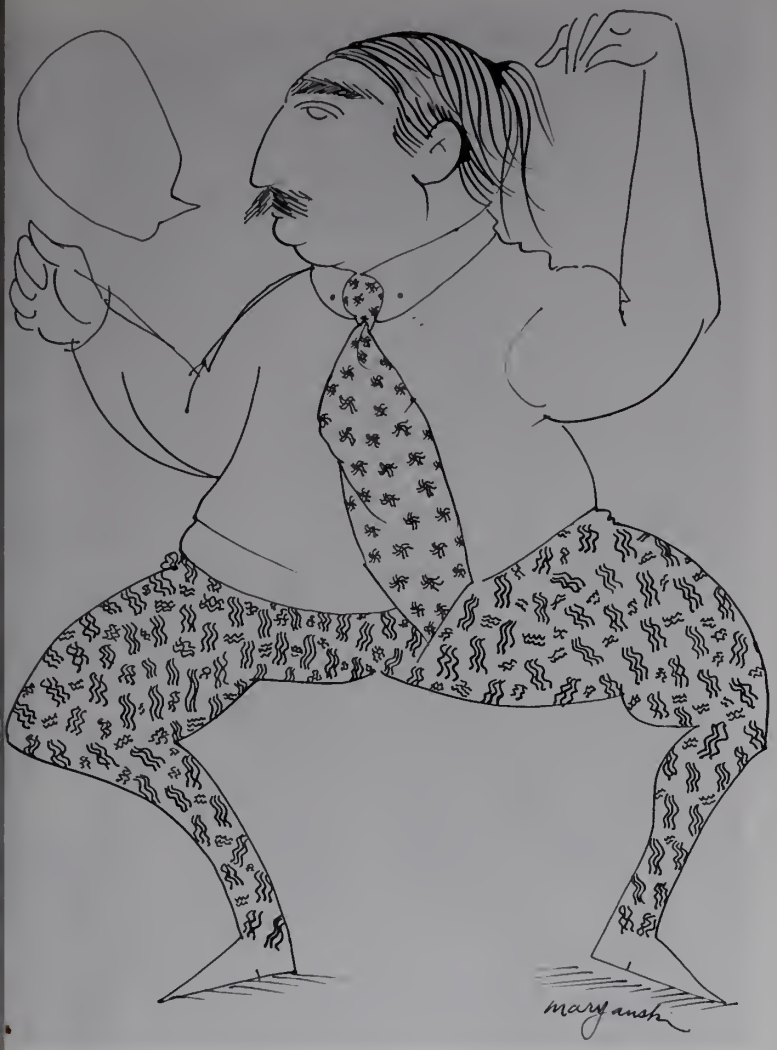
Maurice deG. Ford, Esquire is a lecturer on law at Harvard Medical School and director of the Harvard Family Law Project in Cambridge. Thomas G. Gutheil '67 is assistant director, inpatient services, Massachusetts Mental Health Center and assistant professor of psychiatry at Harvard. Dr. Gutheil and Mr. Ford have been sparring partners in the classroom for several years and, to an extent, have absorbed each other's viewpoints as a result. They have come to the conclusion that the experience has either "hopelessly co-opted" or "profoundly enlightened" them both.

** The Psycho refers to the Boston Psychopathic Hospital, now the Massachusetts Mental Health Center*



" at the Psycho*

psychiatrist observes the proceedings.

by Thomas G. Gutheil

As a psychiatrist, I find gratifying Attorney Maurice deG. Ford's description of his courageous venture into the enemy territory of a psychiatric hospital. It is tempting to assume that such educative forays will yield dividends of greater understanding between the disciplines of psychiatry and law — disciplines not noteworthy for their natural rapport, as well demonstrated in recent years by a number of rococo psychodramas modestly entitled "trials." (I have in mind such episodes as the Sirhan and Hearst trials, but there are numerous other examples.)

The psychiatry/law interface is one of great interest and concern to me. I wish to extend somewhat Mr. Ford's lucid depiction of areas of conceptual friction between the two disciplines or perhaps better yet, models. While such a task has filled volumes, I will limit myself to an overview and a reminder centering on three areas of traditional interdisciplinary misunderstanding: alliance, ambivalence and consciousness. I propose that these areas represent problems of reconciliation among the differences in the models themselves; they are not defects or points of superiority.

The alliance in psychiatry is a complex concept, but most compactly stated: the psychiatrist works with the healthy, adult, or rational side of the patient, against the sick, infantile, or irrational side. Such an alliance is basic to psychiatric work.[1] Since the therapist is working against something in the patient, it should be anticipated that at certain points the therapist may appear to be in an adversary relation to the patient; such illusory oppositions are inevitable, and even necessary, in the work of treatment and are resolved by both parties studying the issue and working their way back to an alliance posture by any number of means. In psychiatry the adversary stance is an alliance problem to be resolved.

The adversary position that Mr. Ford espouses is different but as basic to law as the alliance is to psychiatry. The legal model contains the assumption that truth may be extracted by drawing the material of the case upon the rack of cross-examination, essentially through attack and counterattack.

For the psychiatrist, accustomed to having the adversary system within the patient, the personified antagonists of the courtroom present a disconcerting picture. Trained to look for genuine feeling, the psychiatrist is astonished to see opposing counsel, so clearly at the brink of rending each other's throats moments before, leaving the courtroom arm in arm, discussing each other's golf game. The stiff jargon — "I pray your honor's attention" — could not be more remote from the psychiatric orientation of "getting at how it really feels," in further contributing to the sense of affective estrangement and disorientation. It is a joust, but cloaked in the exaggerated, tactful language of the converse of diplomats and kings,

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the nuances of therapy. The psychiatrist, conversely, is frequently viewed as a jailor by lawyers, who believe the involuntarily hospitalized patient should be entitled to the constitutional protections that surround defendants and prisoners in the criminal justice system.[1] Yet both sets of professionals profess the same goals — to ensure the maximum use of human liberty and responsibility.

Whereas medical school training may resemble the grind of law school, the psychiatric residency experience differs markedly from a law school graduate's "residency" in a law firm. The young lawyer is plunged into an often insecure struggle for partnership. To outdo one's peers within the firm, the budding lawyer must demonstrate skill in competing against other lawyers outside the firm. There is great pressure to turn the work product out, to focus sharply on the essential issues in brief and in oral argument and to control, even deny, one's emotions. Feedback from the firm as to "how well one is doing" is periodic and quite honest.

Psychiatric residency training, as I have experienced it at the Massachusetts Mental Health Center, seems a lot more loving. I have felt little sense of competition against each other among the residents, even for chief residencies. First year residents are assigned to a group, chaired by Dr. Max Day, so they can discuss their feelings both about the hospital and each other. No such groups exist at Ropes and Gray. Young lawyers are expected to hone their verbal and written skills. Much of psychiatric residency training seems devoted, by contrast, to *un*-learning such skills; it is, in many aspects, a non-intellectual experience. Lawyers tend to zero-in on a patient's external communication, and not hear "what is really going on" internally. It is much more important for a resident to feel the transference than to detail the precise content of the words a patient has employed (often in the service of covering up "reality"). To be certain, the difference between psychiatric residency training and law firm training is seldom black and white. On balance, however, much more of a resident's training seems devoted to learning to sit (for a year or much longer) with a patient's suffering, to avoid premature closure, and to resist the temptation to come quickly to a plan of action.

A crime — destruction of life for property — is a crime. But for psychiatrists, such acts are symbols of, and often solutions to, internal conflict. "Reality" is not so much what "is," but a point of view based on cumulative experiences. What the lawyer seizes upon as salient may seem superficial or ultimately irrelevant to the psychiatrist. Whereas getting the client "off" is a major concern of the lawyer, the task of therapy may be to get the patient to face up to responsibility, and this may involve very lengthy work. Small wonder is it that many psychiatrists view what lawyers do as essentially a game, with the results of the adversary system bearing rather little relation to "truth."

A related matter is a disagreement over the extent to which action is a product of free will. This is a difference in degree rather than kind. The law makes allowance for psychiatry to

Fighting the good fight. Says the lawyer: strict attention must be to what the patient does not tell us.

adduce proof of a defendant's diminished responsibility or lack of guilt by reason of insanity. But society's standards, as they are embodied in our law, are on the whole less tolerant of deviance than are psychiatry's. A prosecutor does not have, or take, the time to find the early childhood or unconscious precursors of a potential defendant's conduct.

"The growth of the common law has been in the interstices of procedure" is an axiom familiar to every first year law student. Due process is the lawyer's byword. The law is, in general, as much concerned about the *procedures* by which a decision is reached as about the correctness of the decision. Whether a particular criminal defendant is innocent or guilty is not, in the final analysis, as important as whether an individual has been given the *Miranda* warnings[2] by the police, had legal counsel and been tried by a jury of peers, with strict attention paid to the rules of evidence. Whether a mental patient is committed or not to a hospital's care is secondary to guaranteeing his or her constitutional rights and ensuring representation by an attorney who can arrange for competing expert testimony and pursue cross-examination vigorously during a commitment hearing.

aid to the rules of evidence. Says the psychiatrist: we must listen

To the psychiatrist, however, fair procedure is often synonomous with intolerable delay, and almost certainly, aggravation. Doctors are suspicious about the degree of truth or therapeutic benefit that can emerge from the adversary system.

Conflicts come up in daily practice at Massachusetts Mental Health Center in three areas:

Civil commitment. The staff has long been reluctant to commit patients involuntarily to the hospital, contrary to some popular impressions about psychiatrists. It is invariably easier to do therapy with a willing patient. When a decision is made to petition a court for commitment, it is done after much discussion and clear conviction among those responsible for the patient's care that he or she is indeed mentally ill and dangerous to self or others or substantially unable to fend independently in the outside world.

Recently, however, the Supreme Judicial Court of Massachusetts has ruled that the hospital must prove dangerous-

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and perpetrated with what seems like the multi-level duplicity of the Cold War.

Ambivalence — that one may have utterly opposing feelings on the same point at the same time — may be one of the trade secrets of psychiatry. It is, of course, a restatement of the patient/client's "inner adversary system." To further cloud the matter, varying portions of conflicting feelings may be unconscious: the bulk of the iceberg may be under water, and the waterline may vary, but ambivalence is still a part of normal human relationships.

In the treatment process, the psychiatrist is accustomed to expect ambivalence to be present, even when not overt. A patient may say, "I have mixed feelings about my mother"; we nod — who that is human does not have such feelings? But if the patient says, "I love my mother," we also nod, but we note that the hate must therefore be in the background, or underground, or dwarfed by the love that the patient professes. (It is doubtless this kind of reasoning, that gives psychiatrists the reputation of having suspicious minds that are always reading meanings into things.)

But what if the patient says, "I want custody of my child" or "I want to leave the hospital"? The psychiatrist hears two aspects to these wishes: I want and I don't want. The lawyer hears only one, the direct testimony of the patient's explicit utterance. It is the psychiatrist's job to draw forth the ambivalence within the patient that the legal model simply does not — and some would argue should not — acknowledge.

Finally, the notion of the unconscious is a stumbling block; everyone is made uneasy by the unknown, the more so if it is within ourselves. This familiarity with the unconscious poses particular problems for the psychiatrist confronting legal reasoning. To give a simple example: if every act, thought, feeling — and crime — is the result of a host of interacting and conflicting intrapsychic forces, what is one to make of the issue of criminal responsibility, the question of whether someone did something because of mental disease or defect? The issue of consciousness troubles the search for truth in both models. As noted earlier, the legal model prescribes that truth be sought through the lenses of the adversary procedure and the rules of evidence. To the psychiatrist, this may include such bizarre-sounding formalisms as the judge's admonition, "The jury will ignore what it has just heard."

Truth is a more slippery notion, as Mr. Ford hints in his essay, since the psychiatrist knows about the human capacity to distort and about the power of the unconscious in supposedly rational matters. (At this point I might do well to make explicit that I now refer to the dynamic psychiatrist; the behaviorist or psychopharmacologist would not recognize these considerations as applying to their work.) A good illustration is Kurosawa's movie, "Rashomon," in which a rape-murder in the forest is described by — if I may phrase it so — the plaintiff, the defendant, the victim and an eyewitness. Predictably, the four stories are vastly different, and each makes the teller look better in some way. The disin-

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ness "beyond a reasonable doubt."[3] This places on psychiatry, as Dr. Alan Stone[4] and others[5] have pointed out, a burden of proof which the field does not have the predictive capacity to meet. Yet the law, representing society's increasing notions of what due process requires, holds psychiatry to this scientifically impossible task. The reasoning of the court is that an individual who is civilly committed stands to lose his or her freedom and, accordingly, is entitled to the benefit of the same stringent standard of proof as that required in criminal cases. Indeed, the stigma that attaches to being labeled "mentally ill" and the physical conditions within particular mental institutions may be worse than those that exist in some prisons.

Psychiatrists hardly enjoy being compared, by the courts, to jailers or their hospitals to prisons. Many believe that the new legal standard may force them to release patients when it is clinically irresponsible to do so. Psychiatrists dread dealing with the mental health civil rights lawyer. As a result of my involvement in the teaching program, this position is rapidly changing, but the lurking fear remains.

Involuntary medication. A second area of increasing tension between lawyers and psychiatrists involves patients' refusal to take medication which the doctor feels is essential for their recovery. Since the 1950s there has been a revolution in the somatic treatment of serious mental illness. The phenothyazines, lithium salt and the tricyclic anti-depressants have proved to be remarkably effective in relieving the acute symptoms of schizophrenia, manic-depressive illness and severe depression. Although many lawyers shriek with horror, and there has been legislation significantly limiting the number of such treatments which can be given, psychiatrists have long known that electro-shock therapy may be the quickest and most effective way to combat intense depression.[6]

Had I not scrubbed in, I do not think I would have appreciated these things. For while physicians are disposed to see "forcing the meds" as intrinsically caring conduct on their part, lawyers are conditioned, by their own training in constitutional law, to view such conduct skeptically, as an unwarranted intrusion on basic rights to bodily privacy. Forced medication raises all those fundamental philosophical questions about "the right to be let alone" that are discussed in freshman humanities courses in college. In *On Liberty,* for example, Mill tells us: "That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him. . . . The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."[7]

But, says the good doctor, many of the patients we have are incapable of being reasoned, or even remonstrated, with. Their very disease causes them to view the medicine we bring them as part of an international conspiracy. That may well be, says the lawyer, but please prove it in court. The law sets forth specific procedures for getting what you want for your patient. Just apply for a guardianship for the purpose of consenting to medication for your patient. But, replies the inpatient service chief, the difficulty does not end there. Many of our patients have no family and no one in their lives willing to serve as guardian. And some are in such sorry mental condition that even if notified a guardianship proceeding will be taking place, they have no capacity to comprehend what is going on or where the court will be sitting. Wouldn't your lawyer's logic require that a second guardian be appointed to receive notice (for the patient) of guardianship proceedings? In one recent case at Mass. Mental, a judge concluded that it did.

"Just as the law should not blind itself to complex issues of causation, psychiatry should not be used as a dodge."

The psychiatrist asks the lawyer where this will all end. Must every instance of refusal to accept medication be made the subject of a judicial proceeding? Many well-trained psychiatrists, who desire to practice their profession rather than law, will soon vote by their feet to leave the public mental health system, where the very neediest cases most demand their services.[8] A number of angry psychiatrists I know have been tempted to hoist the judiciary with its own petard, by flooding the courts with guardianship petitions in every doubtful case.

But to my dismay and surprise, some of the clinicians whom I most respect have come to me asking: "What can we get away with?" or "What do we need to do to avoid a lawsuit?" Often, the physician's well-meaning desire to do good obscures the fact that the Hippocratic Oath most requires one "to abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free."[9]

Psychiatry and the Criminal Justice System. One of the more intriguing phenomena I have encountered is the "shuttle" between the criminal justice and mental health systems.[10] The most common victim is the psychopath or sociopath, who is continually in trouble with the law and whom the courts

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terested eyewitness makes everyone appear an ass, and him we intuitively believe!

Even without defering to the role of the unconscious, lawyers are familiar with disagreements among eyewitnesses, but they believe that the rules of evidence will suffice to prevail over the discrepancies. The psychiatrist who treats a group or a family, however, not only knows that witnesses disagree, but welcomes the disagreement. This is in part because the dynamic psychiatrist is more interested in the dominant fantasies in a person's experience and the associated feelings than in "the facts," knowing that fantasies and feelings exert much stronger and lasting influences.

It is not totally clear to me, despite Mr. Ford's statements, what exactly law and psychiatry have to teach each other at the present historical moment, but I believe that efforts such as his begin to clarify this necessary question. With the foregoing as background let me turn to some remarks in response to his essay itself.

Mr. Ford comments that questions of legal expediency — "what can we get away with" and "what do we need to do to avoid a lawsuit" are those most often asked of him by psychiatrists. I believe, however, that he misreads the meaning and import of the fact that these questions are directed to him. As I know from experience, psychiatric residents take their questions of ethical concern to their trusted supervisors; they take questions of expediency to a lawyer because they believe lawyers to be both interested in and expert at those matters. Though it grieves me to say it, our young psychiatrists do not immediately associate lawyers and ethical concerns. It unfortunately takes little to fix in mind this dissociation — one suicide in a patient pulled out of the hospital on legal grounds over clinical objections is enough.

In such a case, a lawyer is being ethical and living up to the standards of the legal model; lawyers are hired to get their clients out. Yet to the young clinician it cannot help but appear that the lawyer is more interested in law than in the client's life, more interested in acting on the client's wishes than in seeing the total picture, or more concerned that clients "die with their rights on" than that they accept a temporary compromise with their liberties.

A SECOND OPINION

An excerpt of a letter from Thomas B. Quigley '32, published in the *New York Times* of March 9, 1975, reflects on the prospects of medical and legal fraternity.

". . . Both medicine and the law seek the truth; medicine by the scientific method for the relief of human suffering, law by the ninth century method of trial by combat by hired champions for the exchange of money. Two such disparate philosophies can never be reconciled, and law-medicine seminars, institutes, and other meetings and organizations are doomed to failure."

Mr. Ford appropriately notes a concern that psychiatrists often voice: if they become entangled in legalisms they are practicing law and not psychiatry; the presence of a lawyer on the premises as a resource — a role Mr. Ford has filled during his sojourn at MMHC — would then seem to serve as an admirable alternative, since questions can be asked as they arise. But problems arise by asking questions of lawyers.

I have elsewhere delineated the manner in which trainees may take the legal way out when confronted by a demanding clinical dilemma.[2] The degree to which consulting the law before examining the mandates of clinical medicine can go awry is best shown by the Saikewicz decision in Massachusetts.[3] I hope any legal readers will pardon my layman's exegesis of the case as follows:

"It is the psychiatrist's job to draw forth the ambivalence within the patient that the legal model simply does not acknowledge."

Saikewicz was an elderly, nonverbal, severely retarded man with an I.Q. of 10, institutionalized for life, who contracted a rapidly fatal leukemia. Death from the disease would be quiet and dignified; the side effects of the chemotherapy, which would only slightly prolong life, would be not only extremely painful, frightening and uncomfortable, but inexplicable and incomprehensible to a retarded man who communicated only in grunts. It could readily be argued that any physician worthy of the name would decide that care of the total patient indicated aiming at maximum comfort, rather than pursuing treatment.[4] Yet in these litigious times his physicians (quite understandably, I feel) brought the question to the courts.

The law, in fact, eventually gave permission for the humane plan described, but in articulating the view of the Massachusetts Supreme Judicial Court, Mr. Justice Liacos not only refuted the Quinlan case principles for Massachusetts, but also arrogated to the courts the decisions in similar cases through use of guardianship and other means. In my personal view, the cost of asking the law in this instance was a further encroachment on medicine — a further "lawyerization." The future now lies open to the spectre of families fighting in court for permission to allow their relatives to die. It is an entirely unanswered question as to whose decisions are more just — those of physicians or lawyers.

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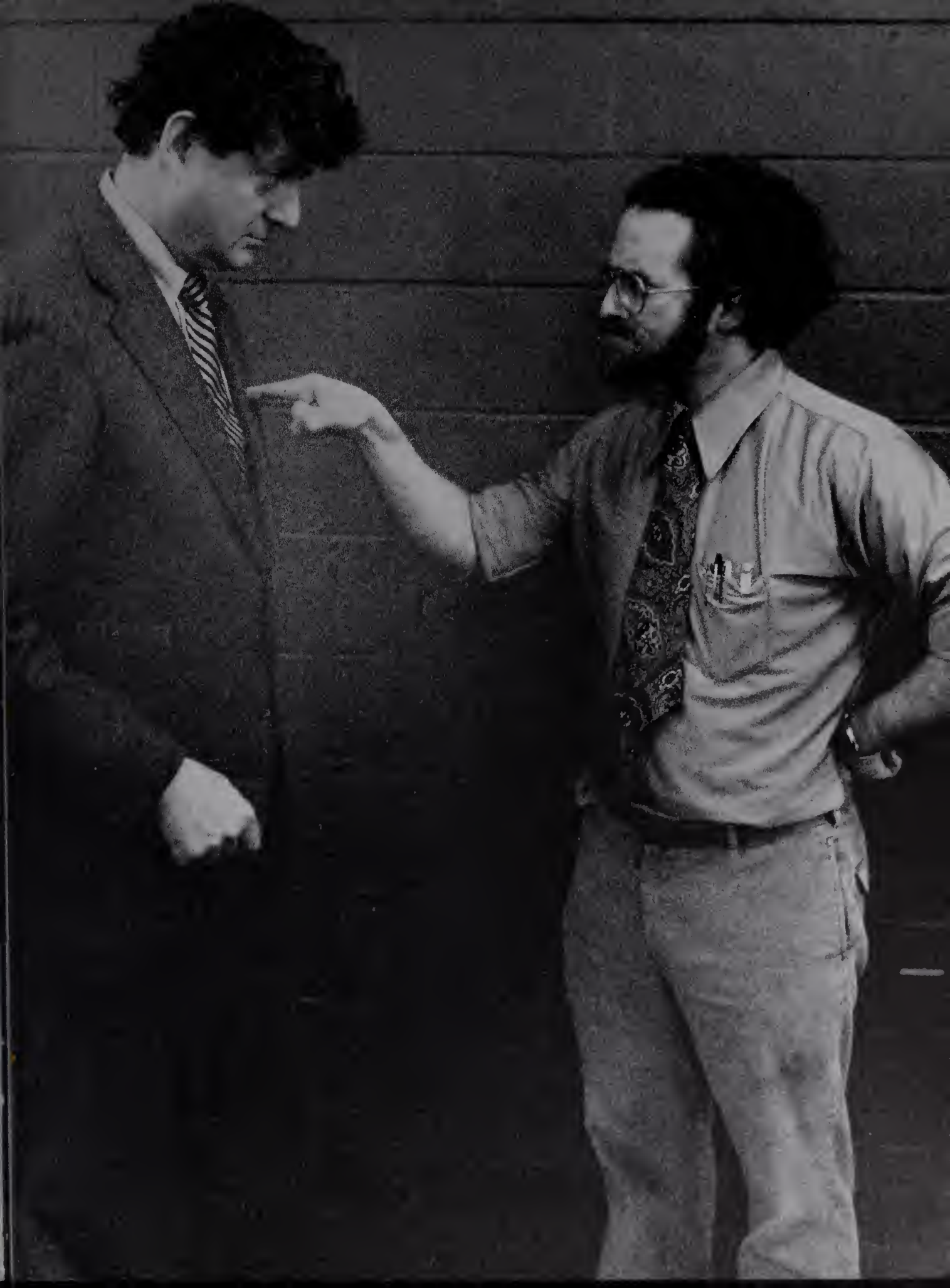

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I am not suggesting that psychiatrists practice in legal darkness on an ask no questions basis; rather my point in this digression is that asking lawyers has, like asking doctors, both benefits and side effects. Do we begin to practice law when we ask lawyers the ethical questions that it is our profession's heritage to address? These questions should be directed not only to ourselves, but to our citizen-patients and to their legislative voice. Whenever psychiatry is abused by the courts, by being subverted as an agent for social control, by being used to take courts off the hook for issues of criminal responsibility or by being used to find dispositions for people not mentally ill, it is the citizen who pays the price and who may well ultimately object to such abuse.

In the 1950s the World Health Organization expressed the belief that the question of involuntary hospitalization had to be decided by physicians;[5] the stigma of judicial proceedings was too great for the matter to be settled by the courts. Today, of course, the pendulum has swung, and our society has taken to the courts with a vengeance, in this matter and in others. We may have long to wait before it swings again, before enough of our chronically disenfranchised population die with their rights on to be noticed and before the cudgels are taken up again in their defense. The change may require, for example, that law students begin to read other psychiatric authors with the avidity now reserved for the works of Thomas Szasz, or that lawyers engage in forays like that of Mr. Ford; but the waiting is difficult because the clinical/legal dilemmas do not wait.

I happen to be of the opinion that law and psychiatry should be amicable but separate. In practice, this would mean that I believe that lawyers should be far less involved in medical or treatment decisions than they now are. Lawyers and psychiatrists should spend some time getting to know each other's viewpoints — but not too much time, to prevent excessive cross-contamination of what each discipline has to offer, to avoid second guessing across disciplines, and to keep clear questions of agency (e.g., who is working for whom). Attempts at amity should be encouraged by educators on both sides, which may ultimately mean discouraging civil rights lawyers from treating psychiatrists as the accused and psychiatrists from diagnosing intrusive lawyers.

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3. Superintendent of Belchertown State School vs. Saikewicz.
4. I am indebted to Dr. Leon Shapiro for calling this issue to my attention.
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MR. FORD

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habitually feel is a little bit strange. So he or she is sent to Mass. Mental for "evaluation," either pending or after trial. If, however, the diagnosis is psychopathy, for which the medical profession has about as few answers as the criminal justice system, the defendant-patient is usually returned to court. The court's response is frequently to return our friend for yet further evaluation.

One young man on the shuttle has had the habit of appearing at practically every hospital emergency room in the city, engaging the full attention of the staff by causing multiple disturbances and refusing to leave. At which point, he is arrested and sent by the judge for evaluation at Mass. Mental. But when the report issues forth that he should be held responsible for his actions, the court cannot quite hear it.

The shuttle involves more frighteningly disturbed individuals as well — the habitually violent or sexually dangerous of-

"Do we begin to practice law when we ask lawyers the ethical questions that are our profession's heritage to address?"

fender whom the courts send to maximum-security Bridgewater State Hospital and who is sent, in turn, to Mass. Mental as a "halfway house." Residents and staff are often in terror of such individuals. Much activity is spent either to keep these people in Bridgewater or to return them there, rather than attempting some sort of modus vivendi.

The availability of a lawyer to assist in "consciousness-raising" about patients' rights has been useful. However, as Dr. Thomas Gutheil, a remarkably observant teacher of both residents and medical students, has pointed out, running to a lawyer and a legal solution may represent too easy an escape for some physicians.[11] The psychiatric problems of so many of the hospital's patients, especially some schizophrenics, seem intractable. The structure of the training program gives the newest doctors, the first year residents, the sickest patients. This is done (due to the influence of Dr. Elvin Semrad), so that they will have a three-year experience of "sitting with" serious illness — human beings at sometimes their most primitive psychological level, without the usual cloak of defenses.

Any solution — medication, transfer to Bridgewater as soon as any major signs of violence surface, or the shuttle back to

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the criminal justice system — often seems better than interminable waiting. And who is a more fitting instrument in this process than the resident lawyer? Rather than struggle with the patient over voluntarily staying in the hospital, the resident can scurry around to find evidence of dangerousness and ask the lawyer to file a commitment petition.

All this is not to say that resorting to the law is not sometimes very appropriate. Yet, as a lawyer who has been on the inside, I have slowly come to the realization that I have, on occasion, been too available to help a resident seeking my counsel. For the legal solution is seldom a long lasting one.

Having seen judges grope while trying to write opinions dealing with questions of equal protection, poverty and deprivations of fundamental human liberties, I originally scrubbed in at Mass. Mental looking for answers that seemed lacking in my field. But psychiatry, I have come to realize, is more an art than a science, closer to the cook stewing the pot, than the promulgator of immutable laws of human development. The converse concern, however, is what the law, and lawyers, can offer psychiatry, other than perhaps antagonism. To what extent can legal procedures be therapeutic, both for the patient and psychiatric resident? I would like to suggest three areas in which we may be helpful.

The first area is the importance of setting out, in ordered form, all sides of an issue, subjecting tentative conclusions to vigorous — even nasty — cross-examination and then coming to a decision. Lawyers have difficulty tolerating ambiguity and vagueness, but our thrustiness and insistence on getting to the point does have something to offer that is generally missing (maybe deliberately) in psychiatry. While their initial experiences being cross-examined may be uncomfortable for psychiatric residents, they usually emerge from the battle taking more care in the evidence they use in their clinical decision making. (This view may, however, underestimate the impact of the intense individual clinical supervision that goes on at Mass. Mental, with its close scrutiny of process notes, "The patient said . . . Then I said.")

A second area is limit setting. The first legal issue in which I was involved concerned an adolescent on one of the inpatient services whose habit was setting fires. Much loving cajolery was tried, but the wastebaskets continued to light up and, one day, almost a whole ward. So the decision was made, in conjunction with me, to trundle the adolescent in question, accompanied by her over-dependent mother, into juvenile court. There the judge in his black robes charged her with arson, thus attempting to bring home, in a formal and ominous setting, the seriousness of what had been done. Getting a patient to face responsibility and to recognize the limits of the concerned tolerance of others is one of the main tasks of psychiatry. Just as the law should not blind itself to complex issues of causation, psychiatry should not be used as a dodge. In the hands of a skilled therapist, it is not.

Third, the law can teach psychiatry respect for its patients' capacities to decide for themselves. In the last analysis, no one has as much material potentially available about motivation and about the demands of inner reality as the patient. Many psychiatrists, to be sure, dispute this. They say "We really *do* know more about you than you do unaided." Many of our mechanisms of defense (some would say all) are unconscious, and a psychiatrist's training certainly helps to bring the patient into some awareness of them. Yet laws that require a formal court hearing — in which the patient-defendant is entitled to be present, to counsel, and also sometimes to expert psychiatric testimony — are an important contribution to a patient's self respect.

As any good therapist knows, to identify the sources of friction between lawyers and psychiatrists or even to speculate about their underlying causes, is only the first step on the way to cure. During my residency at Mass Mental, we have tried to do more. With the help of Drs. Miles Shore and Leston Havens, as well as the directors of residency training, a program has been established that we hope will be a blueprint for the legal education of medical students and psychiatrists, not only here but at other university-affiliated psychiatric teaching hospitals as well.

The work of Dr. Gerald Caplan on the process of consultation has made clear that it is essential to exercise caution about how a potentially threatening foreign body like a lawyer is introduced into the mental health system.[12] In order to gain acceptability and legitimacy, I have found that it is important to be present, not only when legal matters are under discussion, but at an abundant variety of clinical case conferences and staff meetings. The experience has not been free of problems. One resident thought I was a legal spy. Moreover, it is unclear whether attempting to be accepted as "one of them" has been entirely useful. A lawyer is often prized precisely because of a difference — in style and point of view. Curiously, a by-product of this experience has been further confirmation of my identity as a lawyer. One further caveat. A number of attempts have been made to enlist me as the institution's lawyer. But this would impinge upon my neutrality as a teacher. For one can only teach if one is free to disagree. Such freedom would be circumscribed were Mass. Mental my client.

For several years I, and two Mass. Mental psychiatric residents have taught first year medical students part of their basic behavioral science elective. For the students, seeing patients represents their first, craved-for clinical contact. Patients have talked with us about what it feels like to attempt suicide, and young psychiatric residents have described their feelings upon losing a patient, often after long struggle against these suicidal impulses.

We have also tried some pedagogical experiments. One consisted of giving the medical students a classic paper on psychopathy. When they were sure of the qualities that made up the diagnostic entity, we then presented a typical patient from the inpatient services. He claimed that he had his own notions about therapy and was probably more experienced and competent than his resident doctor. The patient's beguiling sincerity and super-normality were symptoms that would confirm a psychiatrist's suspicions. The patient even wanted to stay and participate in the clinical discussion of his case, but was graciously forced to leave. The medical students

were grateful to us for finding a patient that matched so well the descriptions of psychopathy. Only then did the teachers re-introduce the patient, a third year psychiatric resident, who was, in fact, all of the things he claimed, except a patient.

First year students have attended commitment hearings and heard patients bitterly complain about having been involuntarily deprived of liberty. Both from the differing backgrounds of the teachers and the confrontations that have taken place at the hearings, the students have developed some sense of the different ways in which lawyers and doctors approach the mentally ill. The class has made a number of field trips: to the sexually dangerous unit at Bridgewater (with its indeterminate sentences), to the Washingtonian Center for the Addictions (when is addiction a crime?), and to a juvenile detention and rehabilitation center.

We have likewise built the teaching of law and psychiatry into the regular core clerkship for third and fourth year medical students. We attend sessions of criminal and juvenile courts. The first thing students notice in criminal court is the squalor, the lack of legal preparation and the inefficiency. It is a sordid setting; lawyers often meet their clients for the first time in the corridors of the courthouse. So great is the law's delay that the most impressive aspect is what does *not* happen. One of the medical students aptly called municipal criminal court the "emergency room" of the legal profession.

The directors of training have believed that the most effective mode of resident education about legal issues is to make them an integral part of the teaching conferences on the services. The more I have attended case conferences, the more I have become skeptical about the sole presence of any one professional — lawyer, psychiatrist, or social worker — within an interdisciplinary setting. There are few right legal or psychiatric answers. But we all profit from being exposed to many points of view. One of the most exciting aspects of this work is that many of the legal issues are so novel that there is very little decided case law on them. Thus lawyers and psychiatrists working together have an opportunity to shape the law in important ways.

The standard method of conducting the clinical case conferences at Mass. Mental is to have a resident and a social worker present a patient's psychiatric and family history to a senior psychiatrist. We hope, increasingly, to involve a number of lawyers in our conferences. Certainly, the Boston area has a strong "mental health bar" and a wealth of teachers of family law, law and psychiatry, poverty law and constitutional law (many psychiatric issues have constitutional dimensions).[13] The experience of participation in case conferences should be useful, as well, to law teachers especially. Clinical teaching, long the mainstay of medical and residency education, is quite new at law schools and we have a lot to learn.

Mass. Mental is a painful place in which to work and be. One encounters a new dimension of poverty here — a dimension that courts have difficulty in confronting — the blighting poverty of incapacity to form meaningful and stable human relationships, with its resultant loneliness and despair. This may be, far more than inadequate housing and education — which lawyers and courts *do* try to do something about — the most corrosive poverty of all.

I have tried to bring some awareness, to medical students, residents and the other mental health workers on the staff, of what "thinking like a lawyer" has to offer. It is a wonder, given who we are, how law school and medical school shape us, and how our early residency training differs, that lawyers and psychiatrists do not come into conflict even more often. Yet something can indeed be done to reduce these conflicts. The educational proposals outlined for law and psychiatry reflect the start that Harvard Medical School and Mass. Mental have made.

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9. Hippocrates, trans. W.H.S. Jones, *The Loeb Classical Library* (Cambridge, 1923) 164.
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11. Conversation with Dr. Gutheil. See T. Gutheil, Ideology as Resistance: A Supervisory Challange 49(2) *Psychiatric Quarterly* 88 (1977).
12. See G. Caplan, *The Theory and Practice of Mental Health Consultation* (1970).
13. Many of these lawyers work in isolation, however, it is important to have regular gatherings for them to keep abreast of, and discuss, current issues in law and psychiatry.

Acknowledgements

I particularly wish to thank Dr. Miles Shore, Dr. Leston Havens, Dr. George Ainslie and Dr. Thomas Gutheil for their assistance in exposing me to the complexities of psychiatry, both through their teaching and many discussions. Professors Frank Sander, Alan Stone and, particularly, Andrew Kaufman of Harvard Law School, at a slightly earlier period, opened my eyes to the importance of interdisciplinary work and assisted in establishing the Harvard Family Law Project.

Three views of a compound microscope built in the mid-1680s by Joseph Campani, an Italian instrument maker.

Tracing technology's sway

"Men are most apt to believe what they do not understand" said Montaigne (1533-1592), considerably before the onset of the age of technology. Can history give us the perspective necessary to loosen technology's grip?

by Ward Casscells

Medicine and the Reign of Technology, Stanley J. Reiser, Cambridge University Press, Cambridge, 1978, 231 pp.

If there are two recurring themes in the chorus of complaints directed against modern American medicine they are probably these: the costs are going up and the quality is going down. By "quality" the public usually means having doctors who are accessible, both geographically and personally. More specific complaints are voiced by professional critics of the medical establishment such as Thomas McKeown and Ivan Illich, who question whether iatrogenic disease might not largely offset the benefits of modern care.

The blame for both ills — cost and quality — is frequently laid at the door of technology and criticism is increasingly directed against the continued technologizing of medicine. Recently Congress created the National Center for Health Care Technology to study the application and consequences of further technology in medicine. Before an instant solution is proposed, however, it is worth noting that this is no instant problem. Physicians have been criticizing technology's influence since the nineteenth century. Harvard's icon Francis Weld Peabody, while acknowledging the benefits of technology, worried in 1922 that it was "frequently alleged that many of our medical schools and teaching hospitals are producing 'laboratory men' instead of clinicians . . . The need in clinical medicine continues to be . . . not for better technicians but for better clinicians."

The historical perspective is only one of many contributed by Stanley J.Reiser in *Medicine and the Reign of Technology* — the attempt of a physician and teacher of medical history to convey to a wide audience some sense of the changes wrought in medicine, especially medicine in the United States by advancing technology. Though the book is richly documented, and the writing style formal, the overall effect is that

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Ward Casscells is a fifth year student doing research in cardiology.

"Almost as soon as they were accepted these devices ceased to aid in physical diagnosis and began to supplant it."

of a succint, colorful account that emphasizes a clear message: the technology that played so essential a role in the triumphs of scientific medicine has exacted a great price in return.

Reiser argues that the introduction of new techniques stimulated research and the exponential growth in basic medical knowledge, in the same way as the development of the electron microscope and the ultracentrifuge have brought forth a whole new science of cell biology. Merely to operate and interpret the stethoscope, the microscope, the endoscope, the x-ray and the electrocardiograph required special knowledge and skills.

As long ago as 1910, William Mayo concluded that, "The sum of medical knowledge is now so great and widespreading that it would be futile for any one man . . . to assume that he has a working knowledge of any large part of the whole." Specialism and mutual dependence were the direct outcome, according to Reiser; specialists and their machines naturally tended to pair up in large hospitals in the cities. Doctors found less and less time to spend with their patients, as they spent more with each other, their machines, and technicians. Doctors separated themselves both intellectually and emotionally from their patients.

In support of this evolution, Reiser relates the origins of various medical techniques — their invention, their initial reception, which was often quite cool on the part of established practitioners and professors, and their subsequent triumph in the hands of the independent-minded young. The introduction of the stethoscope promoted the concept that diseases are specific entities, characterized by specific symptom complexes, and localized in specific organs. Diagnosis now could be approached directly by the physician, who previously had relied heavily on the patient's own account, aided by little more than an individual's general appearance and pulse, and an inspection of the urine.

Reiser does not quite do justice to the genius of Vesalius, Harvey, Morgagni, Sydenham and others, who laid not only the groundwork for scientific medicine in general, but also for the notion that diseases were localized and locatable. Some advances cited in *Medicine and the Reign of Technology* are admittedly more dependent on technical progress, such as Virchow's theory that all diseases resulted from specific cellular derangements, which could hardly have been conceived without the invention of the microscope. But did factors other than internal stepwise scientific progress give rise to the microscope? Did an increasingly secular, scientific and materialistic climate of opinion make the late 1600s ripe for grinding lenses, which could have just as well been done centuries earlier?

Tools do not, by themselves, give rise to ideas, and although Reiser does not quite make such a claim, it is clear that, given the old saw that man made tools, and tools make man, *Medicine and the Reign of Technology* emphasizes the latter. From this standpoint the work is perhaps open to some criticism, since the author does not lay out the kinds of premises he uses as a historian. Should medical history be a history of medical science, a history of clinical medicine, a history of inventions, a history of persons or ideas, or of class struggle and other economic forces? While the author has not attempted to write a comprehensive history, it may not be completely clear, at least to a general reader, what he has included and what he has left out.

Except for this quibble, the book can hardly be faulted. Reiser amply annotates the golden era of physical examination that was ushered in by the stethoscope and that was enriched with the knowledge derived by the x-ray, by microscopy, by body fluid chemistry, electrocardiography and the like. The going was not always smooth; Sir James MacKenzie, the great British cardiologist, argued that the x-ray and EKG would "blunt the senses and the acute perception of the clinical observer."

All admonitions went unheeded as word of the x-ray filtered down and caught the general public's fancy. While it soon became the rage with New York society ladies desiring x-rays of their jewelry-laden hands, it was greeted with skepticism by *Punch:*

O, Roentgen, then the news is true,
And not a trick of idle rumor,
that bids us each beware of you,
And of your grim and graveyard humor.

The fondest swain would scarcely prize
A picture of his lady's framework;
To gaze on this with yearning eyes
Would probably be rated tame work!

Almost as soon as they were accepted these devices ceased to aid in physical diagnosis and began to supplant it. Yet, the x-ray, the EKG, and the serum value made for less ambiguous communication. Their results were reproducible, quantifiable, and seemed to allow little room for differences in interpretation. (The stethoscope encased in glass and given to Dr. Merrill Sosman by Peter Bent Brigham residents in the 1930s carried a label that read: "Rare and unusually well preserved fragments of an instrument known as the stethescope (sic) . . . actually in general use until the Roentgen era.")

Measuring the lung's vital capacity with a spirometer, 1846.

"Results were reproducible, quantifiable and seemed to allow little room for differences in interpretation."

Physician and patient alike came to trust technological data implicitly, and in fact to use it uncritically. Reiser summarizes several of the studies, done in recent decades, which document the rather large amount of error in diagnosis. The first kind are strictly technical — mislabeling, contamination, and human and machine errors in the performance, recording, and reporting of the test. Other problems result from misinterpretation of tests such as a lack of awareness of the effects of drugs, emotions, biological rhythms, and other variables on serum constituents. In addition there is the problem of the false positive result, where misunderstanding can be tragic, as with the overdiagnosis of syphilis by the Wassermann test.

Reiser points to several studies that show how the increasing cost and morbidity of invasive procedures may offset their benefits, even in strictly medical terms, not to mention the psychological costs of a weakened doctor-patient relationship. Many physicians among them James Mackenzie, Richard Cabot, Sigmund Freud, George Pickering, George Engel, and Alvan Feinstein have attempted to redirect attention to the patient and away from the diseased organ, and to restore confidence in the physician's bedside skills and critical clinical judgment. The conclusion that "today's physician must rebel" against the pernicious aspects of technology is now conventional wisdom in many quarters, but Reiser's appeal is nonetheless eloquent and bold, gracefully stated, and free from the shrill tones of righteous indignation.

Unfortunately the book is too short to be all-inclusive. It lacks any mention of many of the newer "halfway technologies," as Lewis Thomas calls them, — coronary bypass surgery, renal dialysis and many cancer treatments — that are capable of palliating or of prolonging life but rarely of restoring it. Nor does the author discuss, as he has done elsewhere, the ethical dilemmas posed by new techniques for life support or prenatal diagnosis. While the book details the course of the technologic "disease," it falls short of an etiologic diagnosis, and therefore of a prescription. In fairness the author may only have intended a narrative. Still, by its assumptions the book gives the impression that the preeminence of technology was inevitable. *Medicine and the Reign of Technology* represents a great advance over the catalogue of inventions and names that have often passed as histories of medicine, even if it leaves the how and why for the reader to infer.

Part of the difficulty may be that Reiser has not explicitly distinguished, for the general reader, among sicentific, technologic, and clinical progress. Though these influences are all more or less symbiotic, they also can act independently — abstract science for its own sake, technology in industry, and clinical medicine on an empirical basis, as with the digitalis and lime juice remedy prevalent in the eighteenth century. Technology seems to have acquired a momentum all its own in medicine.

The original impact of a device like the stethoscope — bringing the patient and doctor closer together — has become inverted by an overgrown web of technology. As neatly expressed by Dr. George Silver of Yale, medical technology has been a good servant but a bad master. To foster its development will probably require a closer analysis of the social and economic factors that fostered the development of technology. *Medicine and the Reign of Technology* will not please everyone, but it was presumably not meant to do so. If, as has been said, the tail of technology is wagging the dog, then Reiser has at least gotten hold of the tail and is trying to get a good look!

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Letters

Of medicine and machines

Congratulations to you and your staff on the delightful September/October 1978 edition of the *Harvard Medical Alumni Bulletin.*

How I wish that Dr. Elliot P. Joslin who restarted the *Bulletin* in the 1920s might have seen this issue.

The article "Being honest when technology fails" is most impressive and should help many who have to face that problem. Many of the other articles and letters are most interesting.

Albert A. Hornor '11

On behalf of all those who are learning medicine, I would like to both congratulate and thank the editors on the recent *Harvard Medical Alumni Bulletin:* "Managing our machines." All five articles comprising this issue are thought provoking and controversial, together providing a cross section of the major dilemmas facing this rapidly evolving profession. Of particluar interest is Stanley Reiser's discussion of current trends in the technology of diagnosis. The arguments in favor of the use of technology in assessing a patient include supposed objectivity, greater sensitivity and reproducibility, thus providing welcome unambiguous evidence for malpractice suits, although these assumptions do not always hold true. For instance, Dr. Reiser has clearly pointed out the variation in diagnostic results reported for both radiographs and laboratory tests. Other factors against technological dependency in medicine include the weighty financial burden, iatrogenic side effects, and increasing depersonalization of patient care. Yet the situation is far from hopeless — even today, as students in physical diagnosis, we are taught that over ninety percent of patient information is obtained through the history and physical exam, laboratory data usually only backing up physical findings. Thus the importance of the art of medical observation is being stressed continually.

Yet, often it does seem that in striving to heal efficiently there is no time for compassion. Elisabeth Kubler-Ross remarks:

"He may want one single person to stop for one single minute so that he can ask one single question — but he will get a dozen people around the clock, all busily preoccupied with his heart rate, pulse, EKG . . . but not with him as a human being . . . Those who consider the person first may lose precious time to save his life!" (*Death and Dying,* p. 9)

No matter what intervention we ultimately provide, the fight against disease is rarely a painless process for either patient or doctor. T. S. Eliot has written:

Beneath the bleeding hands we feel
The sharp compassion of
the healer's art
Resolving the enigma of
the fever chart.
("East Coker," *Four Quartets,* p. 29)

Currently, medicine aims more at ultimate caring rather than curing. Consequently, a working code of ethics must never lose sight of the patient as a person in need and ourselves as *tools* in the campaign supporting human dignity. In "Being honest when technology fails" Ned Cassem points out: "When our technologies are no longer appropriate, certain extreme measures are still indicated — exacting responsibility, extraordinary sensitivity, heroic compassion."

Someday, technology coupled with research may eradicate disease, leading to a "noble breed" of people, as Plato envisioned in *The Republic.* Yet if we lose our humanity in the process, the effort will be self-defeating. To support the good of the individual, both the science and the art of medicine must be taught and implemented. Let us continue to strive for excellence in both respects.

Mary E. Sunday '80

The recent article by Ernest Cravalho on "Choosing Our Means" reads to me as a depressing misunderstanding of the history of medicine and particularly the history of medical discovery and innovation.

The author uses the word "technology" as if it were a noun referring to a single advance, rather than to the whole "science of developing methods." Why he persists in this use is not clear. In referring to a single technical advance, the word "technique" can be used. Although fashionable, it is a linguistic barbarism to refer to a new procedure as a "new technology."

But aside from this lapse in his use of the English language, his article is based on the concept that as an advance in biosciences is in its most germinative stage, one can somehow divorce the effort and genius involved in its discovery and development, from later concerns as to how it will be used. He seems to visualize a group sitting around in comfortable chairs (presumably in the Dean's office at the HST school) deciding what the work of some other hard working scientist will mean. That is just not the way science has evolved nor is it the way in which new techniques can be fostered.

Let us consider insulin. Here was a superb example of what Cravalho called an "emerging technology." There was tremendous effort and there were many years of work as well as much pure brilliance expended in the isolation of this hormone and finally its manufacture from animal sources. Would it have been possible at that time to stop or control this development which was to be regarded as a "cure for diabetes?" It was perfectly evident to many people within just a few years that it was nothing but palliation and that it probably held back research in the pathophysiology of diabetes for two decades. But think of the thousands of patients who were immensely benefited despite the use of this "halfway technology."

Consider dialysis and transplantation. They have no impact whatsoever on the basic disease process. Would it have been possible in 1948 to foresee, when the first artificial kidney was being perfected in this country on Kolff's model, that within 30 years our government

would be spending almost two billion dollars a year on its use? Could we have predicted in 1951 that there would have been 150,000 transplants done worldwide and with a patient survival rate at 85%, with family donors? There are lots of patients leading enjoyable lives despite this halfway technology.

It brings no comfort to the mother of a blue baby to be told that, afterall, the operation is entirely useless in preventing the anomaly or effecting its occurrence in other children. To tell her that the operation will accomplish very little other than giving her child 15 or 20 years of pretty good life, accomplishes nothing.

Medical advance and the development of innovative techniques to help patients may not always solve the basic problem of disease. And their later utilization simply cannot be predicted by a group of impartial observers, sitting around a conference table.
In the biomedical sciences we need more doers who are at the same time dreamers . . . and fewer planners afflicted with the current theory of what to do with a "new technology."

Francis D. Moore '39

Recount

The September/October *Alumni Bulletin* contains an omission that is minor in the Grand Scheme of Things, but grievous to those of us who care. To wit, in your summary of colleges represented in the Class of '82, you omit Columbia, with seven graduates — Dryer, Dubin, Huang, Rhodes, Schifilliti, Schwartz and Shinnar. If you add the Barnard alumnae (Abraham, Stone), then the university vaults ahead of Stanford to third place.

In the interest of accuracy, I remain

Unnamed

Our anonymous correspondent is right — Columbia should have been number three. We decided that a recount was in order and found that earlier statistics provided by the admission office were in error. To wit, the top ten grossers for the Class of '82 were: Harvard/Radcliffe, 34; Yale, 17; Columbia/Barnard, 9, MIT, 7; Princeton, 7; Stanford, 6; Williams, 5; UC-Berkeley, 4; Johns Hopkins, 3; and Brown, 2. — The editors.

HCHP goes west

Since my graduation from Harvard Medical School in 1959, I have contributed annually to the Harvard Medical School Alumni Fund without fail and this certainly has been one of my pleasures. It is with some sadness that I shall not contribute this year nor in the future or at least until that time when my medical school honestly and in forthright fashion discusses its role in the development and propagation of the Harvard Community Health Plan. As you must know, the Harvard Community Health Plan is a well organized and successful prepaid medical program functioning in the Greater Boston area with active intentions of spreading further into the suburbs in the very near future.

I firmly believe that prepaid medical programs of various types have the right to exist and to compete with the more traditional forms of health care in the marketplace. This type of competition is an important part of the American system. However, I am very distressed to find that my medical school has given its name (a rather important name to say the least) to one particular prepaid program which is now called the Harvard Community Health Plan. As best that I can understand, the Harvard Plan hires a variety of physicians not necessarily the graduates of Harvard Medical School and this plan is also anxious to affiliate with hospitals not necessarily affiliated with Harvard Medical School.

Recently it has been announced that the Harvard Community Health Plan will be opening a large branch in Wellesley, Massachusetts only a few hundred yards from the Newton-Wellesley Hospital which is a large community hospital affiliated with the Tufts University School of Medicine. [*Dr. Sidd is an associate professor of medicine at Tufts University School of Medicine.*] I personally am not bothered nor are many of the other physicians in this area by having to compete with a prepaid program as discussed above but it is distressing to have to compete with the name Harvard. Already a number of persons and patients in my community have quite frankly discussed with me the fact that it would be perhaps advantageous for them to switch their care from their local physicians and the Newton-Wellesley Hospital to the Harvard Community Health Plan because "we will be receiving Harvard care which must be the best."

I seriously question whether the Harvard Medical School has the moral right both to lend their name to a competing form of health care and at the same time solicit funds from graduates of the Harvard Medical School who are forced to compete with the Harvard name. Once again, I stress that it is important and probably good for the various types of medical care systems to compete in the marketplace but I am sorry to see that my medical school has blatantly endorsed one system over her graduates who may be doing conventional health care in Eastern Massachusetts.

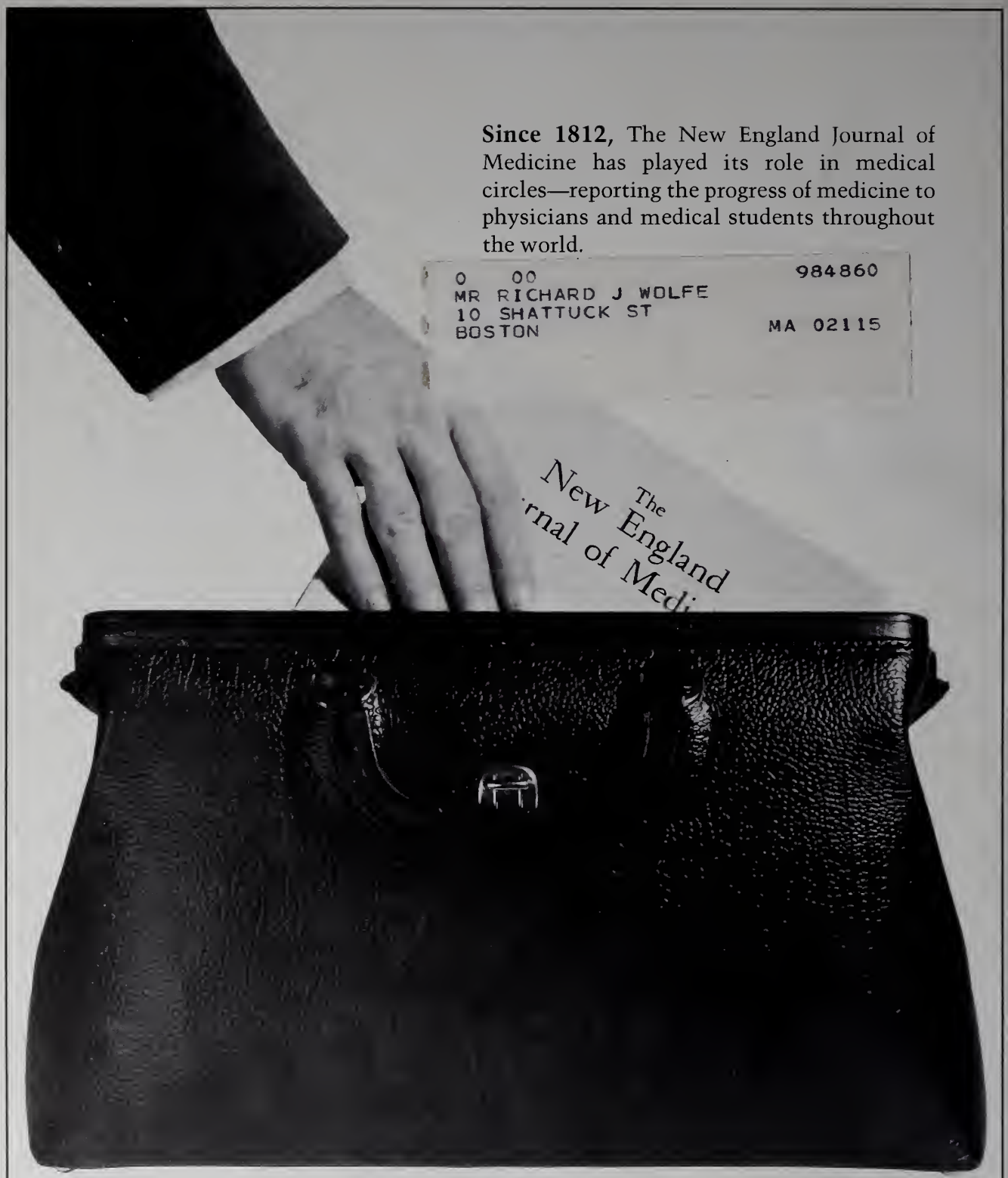
Although I am saddened by my not being able to contribute to the Alumni Fund this year for the first time in twenty years since my graduation, I do hope that other graduates of Harvard Medical School who are practicing in Massachusetts adopt a similar position at least until the Harvard Medical School addresses itself to the above issues.

James J. Sidd '59

Dr. Sidd's letter is in response to the following letter from William D. Christensen '42, president of the Alumni Association, sent to the alumni/ae. — The editors.

The great strength and vitality of the Harvard Medical School are well described in the Institutional Self-Study published in the May/June issue of the *Alumni Bulletin.* I hope you have read it. Alumni can take pride in this appraisal of their Alma Mater. Certain financial trends that are disclosed justify asking alumni to concern themselves with the import of the following fiscal items.

1. *Budget:* a) The 1976-77 operating budget for HMS and the clinical departments in its teaching hospitals was approximately $200 million. b) The budget for HMS and its preclinical responsibilities on the Quadrangle was $50 million.



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